Guidance for the Ethical Allocation of Scarce Resources during a Community-Wide Public Health Emergency as Declared by the Governor of Tennessee

Developed by the Tennessee Altered Standards of Care Workgroup

Version 1.6
July 2016 (revised 2020)

Version 1.6 has been modified by the Tennessee Department of Health and COVID-19 Unified Command, effective June 10, 2020, in consultation with the Office for Civil Rights at the U.S Department of Health and Human Services. Users of this document should disregard prior versions of this Guidance.

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Guidance for the Ethical Allocation of Scarce Resources during a Community-Wide Public Health Emergency as Declared by the Governor of Tennessee

This guidance was prepared by the Altered Standards of Care workgroup, a partnership of the Tennessee Department of Health, the Tennessee Hospital Association, and other industry experts. The workgroup based its thinking on professional literature concerning ethics, emergency response, and public health in consultation with subject matter experts.

To develop Tennessee guidance for altered standards of care a workgroup formed in 2010. The 2010 workgroup reviewed literature on this topic along with the existing plans and guidance from a number of other states that had developed similar guidance to that point. Since that time, additional guidance and resources such as the Institute of Medicine's *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response* was used to update this document. Our workgroup is grateful to the many other organizations and groups for their efforts to further this important work. A guidance document was vetted and released in 2015 from those efforts. In 2016, the guidance was presented to several stakeholder groups across the state and additional revisions were made to bring the plan up with the latest thinking.

It is anticipated that this document will serve as a basis for a great deal of additional discussion for best practices to care for the most people in a major public health crisis and those ideas will be incorporated into this guidance in future versions.

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The purpose of this guidance is to provide government leaders and healthcare professionals with an ethical framework to guide and support decisionmaking at the state, local and facility level during both preparation for and response to a community-wide emergency. By outlining and using these ethical values, the intent is to increase trust and solidarity among all stakeholders, including the general public. Governments, medical personnel, communities and individual citizens mayface ethical challenges as a result of scarce critical resources and overwhelming surges. This guidance is designed to implement measures rapidly to minimize illness and death, as well as the adverse impact on social order and economic stability.

The hope is that community leaders and healthcare professionals will use this information *before* public health emergencies as a basis for planning, tabletop exercises, preparatory drills and educational forums. Use of this guidance *during* a public health emergency will aid in critical decisionmaking. Catastrophic community-wide public health emergencies can raise ethical challenges for healthcare professionals and institutions at every level when the available resources cannot meet the need. In these contexts, the primary duty is to protect the health and welfare of the community, not simply that of the individual.

It is the greatest hope of the workgroup that a public health event of significant enough size to necessitate the use of this guidance never occurs in Tennessee.

Guiding Principles

The following values and principles establish an ethical framework to guide triage and the allocation of scarce resources during a situation resulting in a potential for, or high morbidity and imminence of mortality when sufficient are not available to meet every individual's need.

> **Principles to guide decision makers through community-wide public health emergency planning and response:**

- **Duty to Plan**: Healthcare professionals acknowledge the responsibility to plan for allocation of limited resources during a community emergency with a high potential for morbidity and mortality because an absence of guidelines may leave allocation decisions to exhausted, over-taxed, front-line providers who typically bear a disproportionate burden in major disasters.

- **Duty to Care**: Healthcare professionals have unique responsibilities to provide care during a public health emergency with the potential to cause high morbidity and mortality. During a public health emergency, the primary duty of healthcare professionals and institutions is to the health of the public as a whole.

- **Reciprocity**: The duties owed to professional staff, non-professional staff and the community as a whole should be clearly established prior to a community-wide medical emergency, with clear lines of authority, fair allocation of schedules and worker protections.

- **Stewardship of Resources**: Due to an unavoidable scarcity of resources that may occur in public health emergencies, patients and physicians may not be able to provide every treatment as they typically would. When resources become scarce, healthcare professionals and institutions must leverage limited resources responsibly. Allocation guidelines and triage plans must reflect the goals of reducing morbidity and mortality. A responsible and appropriate stewardship of resources requires some discernment about whether or not use of a scarce resource will be effective for the community as a whole.

- **Respect for Human Dignity**: The most fundamental of these principles is the obligation to respect human dignity. For this reason, emergency operations plans and triage guidelines must be clear to everyone they affect. Every person has an inherent dignity and intrinsic moral worth, regardless of age, race, gender, creed, socioeconomic status, functional ability, disability or any other characteristic. All people deserve equal respect as human beings. With this in mind, the allocation mechanism cannot discriminate based on anything that is not directly relevant to the eligibility of individuals to receive care as established through the triage system.

- **Communication**: Deliberations regarding triage and allocation must be participatory, community-values-based and transparent. Since these guidelines are an alteration from the normal standard of care, there is a responsibility to justify and explain these alterations to the public[1]. Moreover, public and professional cooperation are essential to an effective response. Communicating through forums, continuing education and seeking collaborative input in advance of a public health emergency is a prerequisite to implementation.

[1] See Childress et al, (2002). Public Health Ethics: Mapping the terra in. *Journal of Law, Medicine and Ethics*, 30(2), 173-5

It is recognized that during a significant public health event and the associated declared state of emergency, patients presenting to acute care hospitals may be suffering from conditions not related to the emergency event. **These guidelines should apply to ALL patients seeking care at acute care hospitals during the event. Social worth and other non-medical factors should not be used in the decision making process.** Decisions concerning treatment should be based on an individualized assessment of the patient based on the best available objective medical evidence.

Current State of the Hospitals in Tennessee

The influenza pandemic caused by the 2009 H1N1 virus underscores the critical need to prepare for a public health emergency of significant size and scope that could overwhelm the healthcare system. While the 2009 H1N1 pandemic was not a severe pandemic in terms of numbers of individuals critically ill, the state's healthcare resources were severely strained for several weeks. This highlights the relative fragility of the current healthcare system, given that many of Tennessee's hospitals currently) operate at near capacity in "normal" times.

The 2009 event gives us a glimpse of a scenario in which thousands of people in a region suddenly seek and require medical care. This overwhelming surge on the healthcare system would dramatically strain medical resources and could compromise the ability of healthcare professionals to adhere to normal treatment procedures and conventional standards of care. Attachment B contains specific triage guidance for managing patients during an influenza surge. When limited laboratory resources are available, the Modified SOFA scale can be used (0-19 range) for triaging patients. A reasonable modification of SOFA may be a necessary accommodation for patients with a disability. See Triage Tools Attachment.

Architecture: IOM Report: Guidance for Establishing Crisis Standards of Care

Catastrophic events will have an impact on the entire healthcare delivery system and will affect delivery of care that occurs in the home, community, hospitals, primary care offices and long-term care facilities. A number of strategies can be implemented along this continuum of care to reduce the likelihood that standards of care will change in a disaster situation.

These include steps taken to substitute, conserve, adapt, and reuse critical resources, including the way staff are used in delivering care. All of these steps should be implemented *prior to* the reallocation of critical resources in short supply. Every attempt must be made to maintain the appropriate standards of care and patient safety until the use of altered standards is necessitated.

The Institutes of Medicine defines:

・ **Conventional capacity** as the use of spaces, staff, and supplies that is consistent with daily practices within the institution. These alternate spaces and practices are used during a major mass casualty incident that triggers activation of facility emergency operations plans.

・ **Contingency capacity** as the use of spaces, staff and supplies that is **not** consistent with daily practices, but provides care that is *functionally equivalent* to usual patient care practices. These spaces or practices may be used temporarily during a major casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources). See: strategies section below.

・ **Crisis capacity** as adaptive spaces, staff, and supplies that are not consistent with usual standards of care, but provide sufficiency of care in the setting of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a *significant* adjustment to standards of care.

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Table 1: Institute of Medicine matrix for treatment capacity and level of care

Incident demand/resource imbalance increases ⎯⎯⎯⎯⎯⎯⎯⎯⟶

Risk of morbidity/mortality to patient increases ⎯⎯⎯⎯⎯⎯⎯⟶

	Conventional	**Contingency**	**Crisis**
Space	Usual patient care space fully utilized	Patient care areas repurposed (PACU, monitored units for ICU-level care)	Facility damaged/unsafe or nonpatient care areas (classrooms, etc.) used for patient care
Staff	Usual staff called in and utilized	Staff extension (brief deferrals of non-emergent service, supervision of broader group of patients, change in responsibilities, documentation, etc.)	Trained staff unavailable or unable to adequately care for volume of patients even with extension techniques
Supplies	Cached and usual supplies used	Conservation, adaptation, and substitution of supplies with occasional reuse of select supplies	Critical supplies lacking, possible reallocation of life-sustaining resources
Standard of Care	Usual care	Functionally equivalent care	**Crisis standards of care**

Usual Operating Conditions ⟵⎯⎯⎯⎯⎯⟶ **Austere Operating Conditions**

⟵⎯⎯⎯⎯⎯⎯⎯ **Recovery**

Strategies for Scarce Resource Situations (Contingency Capacity)

A key principle of this guidance is the need to effectively manage increasingly scarce resources – including staff - in an effort to ultimately avoid the use of crisis standards (at best) and (at worst) prolong the time to crisis standards activation and/or the time crisis standards are in use. These strategies would be employed as the situation evolves from conventional to contingency as described above.

Institutions are encouraged to develop strategies in the event scarce resource situations occur, including preparation, conservation, substitution, and adapting according to the severity of the scarcity/shortage. These include strategies for oxygen, staff, nutritional support, medication administration, hemodynamic support and IV fluids, mechanical ventilation/external oxygenation, and blood products. These strategies along with others for scarce resource situations may be used once it is determined that an event is of significant enough size and/or duration.

Notwithstanding any guidance herein to the contrary, decisions concerning whether a patient is a candidate for treatment should be based on an individualized assessment of the patient based on the best available objective medical evidence.

Activation of Tennessee Guidelines for Ethical Allocation of Scarce Resources

Activation of Crisis Standards of Care (CSC) could occur suddenly as may be the case with an event like a large New Madrid earthquake or may result from a slow escalation as a result of a disease. The region of the state affected could also be either large or small. The Health Commissioner in consultation with the Governor's Office will make the declaration with the details for the particular situation. The public and health providers will be notified through Tennessee Emergency Management Agency and ESF 8 communications systems as well as other public communication channels.

The Tennessee Department of Health Mission Coordination Group (MCG) will provide expert advisory input for guidance implementation. The MCG is a standing core group composed of the Commissioner of Health, the Chief Medical Officer, the State Epidemiologist, the Emergency Preparedness Program and Medical Directors. Additionally, the Commissioner may appoint Subject Matter Experts (SMEs) appropriate to the situation to assist in determining policy, objectives, strategies, plans, and priorities for overseeing response activities for and recovery from a disaster that may cause this guidance to be initiated.

A local **decision to implement** the TN Guidance for Ethical Allocation of Scarce Resources guidelines should be based upon the degree of the public health emergency and available healthcare capacity. Specifically, Guidance for Ethical Allocation of Scarce Resources may be initiated only after all of the following conditions have been met:

- Surge capacity is fully employed within healthcare facilities and the healthcare coalition(s)
- Attempts at conservation, reutilization, adaption, and substitution have been performed maximally
- Critically limited resources have been identified (e.g., ventilators, antibiotics)
- Infrastructure resource needs have been identified (e.g., isolation, staff, electrical power)
- Resources and/or infrastructure needs cannot be met by local and regional health officials
- Requests for federal and state resources cannot be timely met.
- The appropriate institutional committee has reviewed and recommends initiation of the Guidance for Ethical Allocation of Scarce Resources

It is imperative that all healthcare coalitions and hospitals work together as much as possible to maximize all available resources. It is recognized that within individual regions and institutions, the criteria for implementation of these guidelines may occur at different times. As such, the decision to implement the guidelines will ultimately be made by individual institutional committees. The recommended committee of each institution should consist of (at a minimum):

      i. The Chief of Staff (or designee)
      ii. The Chief Medical Officer (or designee)
      iii. The Chief Nursing Officer (or designee)
      iv. The Infection Control and Prevention Nurse (or designee)
      v. The Emergency Department Director (or designee)

Communication
Tennessee has developed extensive preparedness and response plans and systems since the 9/11 attacks. The systems are used to actively monitor public health demands and hospital/health system capabilities and resources during major public health emergencies. These systems provide the capabilities for a common operating framework in real or near-real time, including:
- The HEALTHCARE Resource Tracking System (HRTS) which provides monitoring for hospital bed availability, facility status, resource levels/capacities, and other critical emergency response information.
- TDH Emergency Regional Coordinators (ERCs), Regional Hospital Coordinators (RHC) and state EMS consultants coordinating with Regional Health Operations Centers (RHOCs) in every major metro- and regional-area of the state
- Tennessee Health Alert Network (TNHAN) provides e-mail and telephone updates and alerts to key public health and hospital staff

- Regional Medical Communications Centers (RMCC) provide EMS with information on available medical resources

Activation of an event within HRTS engages applicable EMS Consultants, RHCs, ERCs, RMCCs, and hospitals in the affected area. In addition, applicable hospitals outside of Tennessee that are part of HRTS are notified.

The State of Tennessee Emergency Support Function (ESF) 8 response structure consists of 8 EMS regions. There is an RMCC and a Healthcare Coalition coordinating efforts in each one of the EMS regions.


EMS Regions
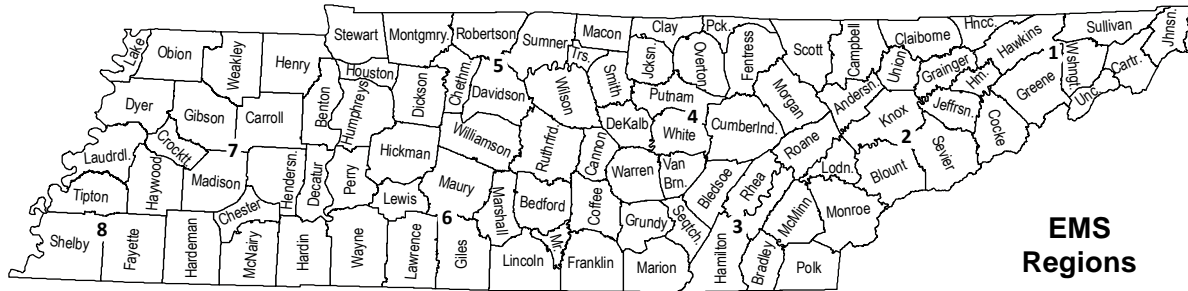
On-going monitoring of public demand and health system capabilities and resources provides the necessary information to instruct all affected hospitals in a region relative to the use of contingency and crisis standards of care. During activation of these guidelines, TDH would provide direction and coordination with 911 centers, RMCCs, and EMS agencies to assure that the altered standards of care where as widely known as appropriate. This coordinating action is key to ensuring that the most appropriate patients are transported to medical facilities while others receive the best care possible elsewhere with the current situation.

Open communication between healthcare facilities is key for an effective response during a public health emergency. Ongoing communication between hospitals should be coordinated through Regional Hospital Coordinators and Healthcare Coalitions as part of the TN ESF 8 Response Plan. Situational awareness will be ensured with frequent communication between each hospital regarding patient volume and acuity experienced by the facility, as well as resource status information. This information will be used to facilitate decision-making to determine when and how altered standards of care are implemented and deactivated. Hospitals will provide ongoing status information as requested by the State. Data will be reported using existing reporting systems. The Regional Hospital Coordinators will monitor data reports for potential trends across the affected areas.

Upon a decision to implement the Guidance for Ethical Allocation of Scarce Resources, the local emergency management agency, the county or regional state health office, and the applicable healthcare partners will be notified by the implementing institution. The communication structure for the activation and monitoring of the TN Guidance for Ethical Allocation of Scarce Resources is illustrated in Figure 1.

Figure 1: Communication Flowchart
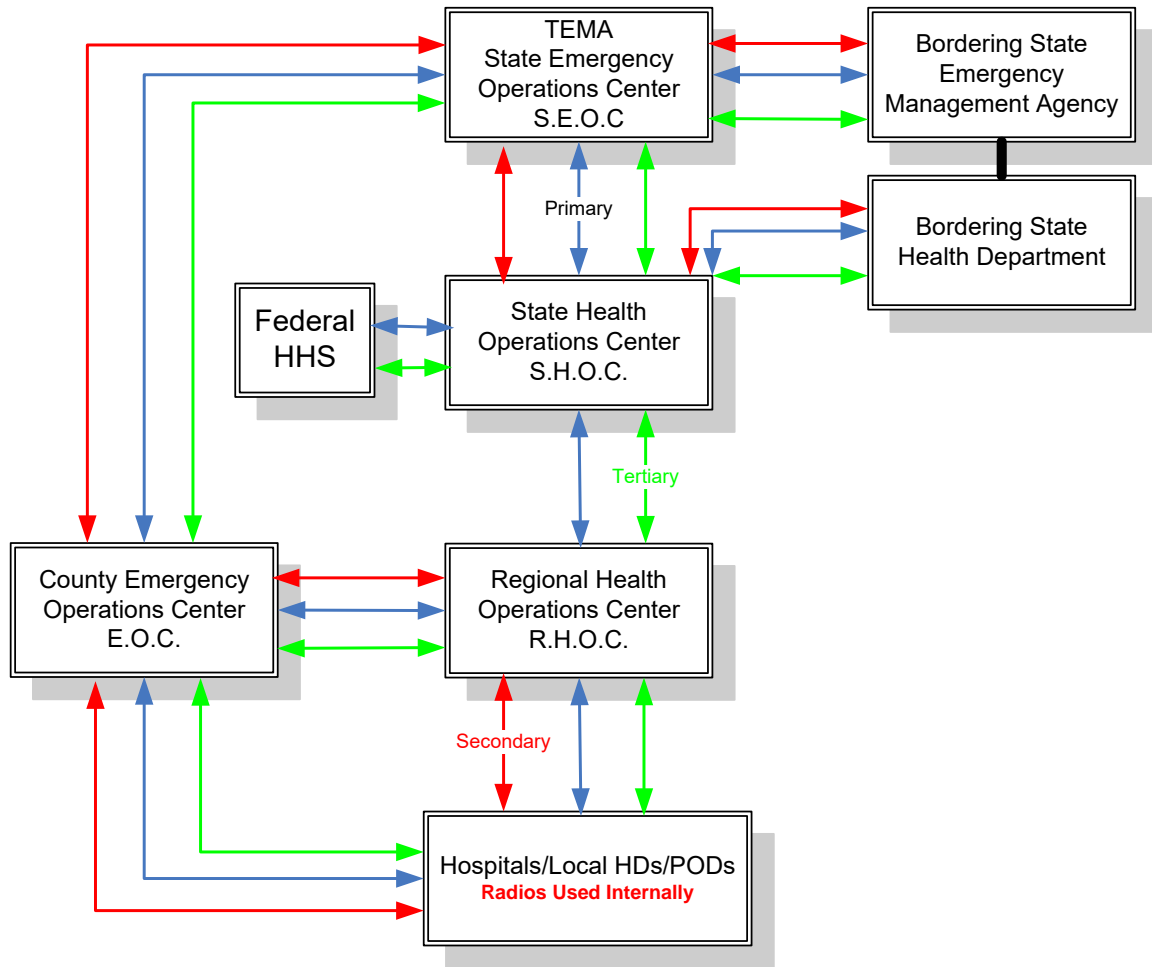
Primary Communications:
Phone, Cell Phone, Email, and Fax

Secondary Communications:
800MHz, UHF, or VHF Radios

Tertiary Communications
Ham Radio and Satellite Phones

It is recognized that hospitals within the same affected region would likely reach the need for implementation of these guidelines at different times. However, recognizing the scope and size (and perhaps, duration) of the event, hospitals still in the contingency phase will not be expected to share their remaining limited resources. As such, the decision to implement the crisis guidelines will be made by the individual institution, after the above conditions are met and consensus has been reached by hospital leadership that no other options exist.

Upon decision for implementation of crisis standards of care, the hospital will notify the Department of Health, which will immediately notify the other hospitals in the region.

It is anticipated that the Tennessee readiness and response system noted above will also function to communicate with the hospitals in the affected region to determine when the crisis standards of care can be lifted.

Hospital and ICU Decision-making

The Altered Standards of Care Workgroup reviewed in great detail the hospital admission exclusions included in many other state plans in the context of the assumptions and scenarios presented previously in this document. Many experts from outside the workgroup were also asked to lend their perspectives.

Given our charge to do the best for the most - saving as many lives as possible with a marked scarcity of resources - there are certain situations where maximally aggressive care will not be able to be provided to every individual. These individuals would include:

- Those who are too ill to likely survive the acute illness (as evidenced by the Sequential Organ Failure Assessment – SOFA - score). A reasonable modification of SOFA may be a necessary accommodation for patients with a disability (e.g., deafness, cognitive or mobility limitations).
- Those whose underlying medical issues make their imminence of mortality probability so high that it is not reasonable to allocate critical care resources to them in a crisis situation, based on survivability probability and an individualized assessment rather than a categorical exclusion.

In cases meeting the above criteria, palliative care will be the priority. Notwithstanding prior versions of this

document, categorical exclusions should be avoided. In addition, resource intensity and duration of need on the basis of age or disability should not be used as criteria.

Decisions regarding resource allocation should be made by a peer-based team of at least three individuals, including an intensivist and other hospital leaders such as the hospital medical director, a nursing supervisor, a board member, an ethicist, a pastoral care representative, and one or more independent physicians. This team provides ongoing evaluation of patients for hospital admission, intensive care admission, and termination of life-sustaining treatment.

Visitation Policies

Facilities may need to limit visitation for infection control purposes. Virtual or electronic visitation methods are encouraged in such circumstances. In addition, visitation policies should address, on a case-by-case basis and in consultation with treating physicians and facility medical directors, visits involving accommodations or other support for persons with disabilities, religious exercise, or end-of-life care, consistent with applicable law and state and federal regulatory guidance.

Care Models for People Who are Not Admitted to a Hospital

When crisis standards of care are activated, certain hospital admission criteria will also be activated. Communities should consider and plan for palliative care models for those people who do not meet hospital admission criteria or who no longer meet criteria to remain in the hospital.

Home health and hospice providers will likely be overwhelmed with the event as hospitals discharge patients to be able to provide for others. However, if home health and hospice staff are available, hospitals should consider planning for these staff to support the overall community efforts, including:

- Admit to home health and hospice services. If capacity is there, this is a natural option.

- Hospice units in the hospitals. Hospices could potentially admit additional patients to existing hospice units and/or staff a unit in available hospital space.

- Directly support hospital staff with palliative care expertise.

- Support for the "atrium" model of care in the hospital by providing medical/palliative care to groups of people who choose or are forced to remain at the hospital but not in a patient care area.

Comfort packs. Many hospices currently provide "comfort packs" for families caring for loved ones at home. In a crisis situation a physician could be on site to write an order for a comfort pack to be sent home (or another location) with the patient/family. Protocol would be established specific to what is to be included in the packs.

Public Dispensing. The current Tennessee emergency Point of Dispensing (POD) system could also be used to dispense the comfort packs. The POD network that has been identified has at least one site in each of the 95 counties in Tennessee. The network currently has over 150 sites established across the state that could also be used to dispense comfort packs or other resources to the public. In addition, TDH has contracted with over 500 pharmacies in the state to provide emergency medical countermeasures. These contracts can be activated to respond to public health emergencies.

Teaching sheets. Comfort care teaching sheets could also be provided to patients and their families. This written information would provide useful ideas for caring for a loved one at home, including information about those diseases not directly related to the event.

These efforts would be in conjunction with an on-going, regularly-updated, disease/event-specific education of the public by experts and public health officials. The public should be provided information about:

- Informational phone hot-lines and other communication channels. When and how to access limited services

- When and why to stay home

- How to care for yourself

- How to care for others
- How to stop the spread of the disease or harmful agents

- Creating a family plan (provided in good times)

- Advance directives

Emergency Credentialing

In a significant public health event, hospitals may experience severe staff shortages in critical areas. At the same time, hospitals are likely to experience physician and other healthcare volunteers presenting to assist who are not members of the hospital/health system staff. Hospitals should do everything possible to adhere to existing credentialing protocols. However the circumstances of the situation may require the use of an emergency credentialing system. *Reference: Memorial Health Care System policy.*

Patient Tracking

Hospitals and other care providers will also be expected to maintain a tracking system for all those sick or injured who present for help, including those who are not admitted to the hospital. At best, this will tie into regional or state tracking efforts utilizing interoperable systems for hospitals and other providers. At a minimum, hospitals should use the HICS 254 disaster victim/patient tracking form, which is included as Attachment A.

Procedure for activating an emergency patient tracking event activation notice:
- The activation of the emergency patient tracking system will occur through HRTS messaging and/or TNHAN.
- Specific instruction based on the event will be included in the message(s).
- Receiving facilities for the emergency patient transports will generally have the initial responsibility to be sure all patients for the event are registered into a tracking system to establish a common operating picture.
- Affected regional Health Operations Centers will coordinate the collection and exchange of patient tracking information.

Under these activations, electronic patient tracking should be implemented where possible as follows:
- Each patient should be assigned a unique patient identifying number.
- Patient identifying numbers can be assigned with an armband, use of an identification card, use of a coded triage tag, registration in a web-based patient tracking system which generates a unique identification number, etc. **The assignment of a unique identification number is critical for tracking patients.**
- The unique identifying number should be used or cross-referenced in all disparate systems to ensure continuity of emergency patient tracking.
- **All attempts should be made to keep patient ID bands from previous facilities on the patient.** If ID band(s) need to be removed, attach the removed band(s) to the patient's records when transporting.

[Remainder of page intentionally left blank]

Deactivation of Tennessee Guidelines for Ethical Allocation of Scarce Resources

The Health Commissioner, in consultation with the Governor's Office, will deactivate CSC when healthcare resources are no longer at a crisis level. Messages with the deactivation details will be sent out through Tennessee Emergency Management Agency and ESF 8 communications systems. Other emergency operations may remain activated even if a state-declared CSC activation is cancelled.

Legal Environment

Emergency management powers of the governor. T.C.A. Section 58-2-107

Section (e)(1) states that the Governor may:

Suspend any law, order, rule or regulation prescribing the procedures for conduct of state business or the orders or rules or regulations of any state agency, if strict compliance with any such law, order, rule, or regulation would in any way prevent, hinder, or delay necessary action in coping with the emergency;

Section (l)(2):

If additional medical resources are required, the governor, by executive order, may provide limited liability protection to health care providers, including hospitals and community mental health care centers and those licensed, certified or authorized under titles 33, 63 or 68, and who render services within the limits of their license, certification or authorization to victims or evacuees of such emergencies; provided, however, that this protection may not include any act or omission caused by gross negligence or willful misconduct.

EMTALA: § 489.24(a)(2) (including Interpretive Guidelines for a federal waiver)
EMTALA provisions may be waived by the Secretary of Health Human Services during a declared public emergency and under the Stafford act. The Secretary can issue the Section 1135 Waiver to waive sanctions for the "transfer of an individual who has not stabilized for both transfers and redirection for a medical screening examination. Waivers are generally limited to a 72-hour period beginning upon implementation of a hospital disaster protocol, unless the Waiver arises out of a public health emergency involving a pandemic. If related to a pandemic, the Waiver terminates upon the first to occur of either the termination of the underlying declaration of a public health emergency or 60 days after being first published. If the waiver terminates because of the latter, the Secretary may extend it for subsequent 60-day periods.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_v_emerg.pdf

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Additional Resources

- Office of the Assistant Secretary for Preparedness and Response (ASPR) Communities of Interest (COI) for Crisis Standards of Care and the Allocation of Scarce Resources - http://www.phe.gov/coi

    About the COI - In response to a 2008 Government Accountability Office (GAO) recommendation, the Department of Health and Human Services (HHS), Office of the Assistant Secretary for Preparedness and Response (ASPR) developed a Communities of Interest (COI) SharePoint site (i.e., a clearinghouse) to better disseminate information and manage documents; share promising practices and ideas; and provide a workspace where users from inside and outside HHS/ASPR can come together to share documents and ideas regarding the crisis standards of care (CSC) and allocation of scarce resources (ASR). HHS/ASPR uses the term "communities of interest" to describe and include all of the interested parties involved in CSC and ASR planning.

- Agency for Healthcare Research and Quality (AHRQ) Altered Standards of Care in Mass Casualty Events - http://archive.ahrq.gov/research/altstand/

Statement on Application of Civil Rights Laws during an Emergency

The Americans with Disabilities Act, Section 504 of the Rehabilitation Act, the Age Discrimination Act, and Section 1557 of the Affordable Care Act prohibit discrimination in HHS funded health programs or activities. These laws, like other civil rights statutes, remain in effect during an emergency. As such, persons with disabilities should not be denied medical care on the basis of stereotypes, assessments of quality of life, or judgments about a person's relative "worth" based on the presence or absence of disabilities or age. Decisions by covered entities concerning whether an individual is a candidate for treatment should be based on an individualized assessment of the patient based on the best available objective medical evidence.

As resources allow, government officials, health care providers, and covered entities should not overlook their obligations under federal civil rights laws to help ensure all segments of the community are served by:
- Providing effective communication with individuals who are deaf, hard of hearing, blind, have low vision, or have speech disabilities through the use of qualified interpreters, picture boards, and other means;
- Providing meaningful access to programs and information to individuals with limited English proficiency through the use of qualified interpreters and through other means;
- Making emergency messaging available in plain language and in languages prevalent in the affected area(s) and in multiple formats, such as audio, large print, and captioning, and ensuring that websites providing emergency-related information are accessible;
- Addressing the needs of individuals with disabilities, including individuals with mobility impairments, individuals who use assistive devices, auxiliary aids, or durable medical equipment, individuals with impaired sensory, manual, and speaking skills, and individuals with immunosuppressed conditions including HIV/AIDS in emergency planning;
- Respecting requests for religious accommodations in treatment and access to clergy or faith practices as practicable.

BULLETIN: Civil Rights, HIPAA, and the Coronavirus Disease 2019 - https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf

Attachment A

HICS 254 - DISASTER VICTIM/PATIENT TRACKING FORM

1. INCIDENT NAME		2. DATE/TIME PREPARED	3. OPERATIONAL PERIOD DATE/TIME

4. TRIAGE AREAS (Immediate, Delayed, Expectant, Minor, Morgue)

MR#/ Triage #	Name	Sex	DOB/ Age	Area Triaged to	Location/Time of Diagnostic Procedures (x-ray, angio, CT, etc.)	Time sent to Surgery	Disposition (home, admit, morgue, transfer)	Time of Disposition

5. SUBMITTED BY	6. AREA ASSIGNED TO	7. DATE/TIME SUBMITTED

8. FACILITY NAME

Attachment B: Initial Triage for Pandemic Influenza

Purpose: Initial triage is intended to help patients who are concerned about influenza determine whether or not they should seek medical help.

Ask these initial questions
1. **Within the past 10 days** has the patient been **exposed to someone with influenza**?
2. Did the patient **get sick fairly quickly**, over 1-2 days?
3. Does the patient have a **fever over 101º F** or 38º C?
4. Does the patient have a **sore throat**?
5. Does the patient have a **cough**?
6. Does the patient have **severe muscle aches**?

YES to **4 or more** of the above

YES to **3 or fewer** of the above

Patient is NOT likely to have influenza and should contact his/her usual source of medical care

Patient IS likely to have influenza. CONTINUE with the following questions.
1. Is the patient **struggling to breathe** or **breathing very rapidly**?
2. Is the **breathing very shallow, slow, or weak? (respiratory suppression)**
3. Are the **lips, tongue, or face blue? (cyanosis)**
4. Has it been **more than 12 hours since the patient last urinated? (dehydration)**
5. Is the patient **too weak to walk to the bathroom** or **not moving around in bed** AND/OR is the **skin pale and cool to the touch? (shock)**
6. Is the patient an **infant younger than 2 months** with a fever, feeding poorly, or with fewer than 3 wet diapers within a 24-hour period?

YES to **4 or more** of the above

YES to **3 or fewer** of the above

Patient should be evaluated by a private physician, urgent care facility, or hospital triage area

- Advise patient to be evaluated if any of the above occurs in the near future
- Reassure patient that the illness is not severe and can be treated at home
- Provide information about self-care
- If available, offer Tamiflu if within 48 hours of illness onset

Tennessee Hospital and ICU Triage Guidelines for Adults
During Crisis Standards of Care
Version 1.4, July 2016 (modified June 2020)

Purpose

The purpose is to guide the allocation of patient care resources during an influenza pandemic or other public health emergency, when demand for services dramatically exceeds supply. **Application of these guidelines will require physician judgment at the point of patient care.**

Basic Premises

- **Graded guidelines** should be used to control resources more tightly as the severity of a pandemic increases.

- **Priority should be given to patients** based on survivability probability and an individualized assessment rather than a categorical exclusion.

Scope

- **These triage guidelines apply to all healthcare professionals, clinics, and facilities in the state of Tennessee.**

- **The guidelines apply to all patients 14 years and older.**

Hospital and Medical Staff Planning

- **Each hospital should:**

  o **Establish a peer-based structure** for the review of hospital admission, Intensive Care Unit (ICU) admission, and termination of life-sustaining treatment. Consider a team of at least 3 individuals, including an intensivist and 2 or more of the following: the hospital medical director, a nursing supervisor, a board member, an ethicist, a pastoral care representative, and one or more independent physicians.

  o **Institute an action team** to provide counseling and care coordination and to work with the families of loved ones who have been denied life-sustaining treatment.

- **Medical staff** should establish a method of providing peer support and expert consultation to physicians making these decisions.

1

Overview of Pandemic Triage Levels

Triage Level 1 Early in the pandemic	Triage Level 2 Worsening Pandemic	Triage Level 3 Worst –case scenario
• Hospitals recognize the need to surge bed capacities • Emergency departments are experiencing increased numbers • Note: In the event of a severe and rapidly progressing pandemic, start with Triage Level 2.	• Hospitals have surged to maximum bed capacity, and emergency departments are overwhelmed. • There are not enough beds to accommodate all patients needing hospital admission, and not enough ventilators to accommodate all patients with respiratory failure. • Hospital staff absenteeism is 20% to 30%.	• Hospitals have already implemented altered standards of care regarding nurse/patient ratios and have already expanded capacity by adding patients to already occupied hospital rooms. • Hospital staff absenteeism is 30% to 40%.

Pre-Hospital Settings

1. **Initial Triage**

   Applies to: Patients who appear for care in physician offices or clinics, or in pre-evaluation spaces for emergency departments;

   Implemented by: Physicians, clinic staff, pre-screening staff

   Other uses: Publish in newspapers, place in websites, etc. for self-use by public.

   ALL Triage Levels: Use INITIAL TRIAGE TOOL (Appendix A) to provide initial triage screening, as well as instructions and directions for patients who need additional care or medical screening.

2. **EMS, Physician Offices, and Clinics**

   Applies to**:** Patients who present for care or call for guidance for where to go or how to care for ill family members;

   Implemented by**:** Primary care staff, hospital help lines, community help lines, and health department help lines

   Triage Level 1**:** Use INITIAL TRIAGE TOOL (Appendix A) to evaluate patients before sending to hospital ED or treating in an outpatient facility.

   Triage Levels 2 and 3: Continue to use INITIAL TRIAGE TOOL (Appendix A). If individualized assessment indicates low probability of survivability, a patient may be sent home with care instructions.

3. **Home Care, Long-Term Care facilities, and Other Institutional Facilities (mental health, corrections, disabilities)**

   Applies to: Patients in institutional facilities

   Implemented by: Institutional facility staff

   ALL Triage Levels: Ensure that all liquid oxygen tanks are full. Limit visitation to control infection (refer to Visitation Policies on page 8.

   Triage Levels 2 and 3: Perform individualized evaluation of patients and do not transfer patients with low probability of survivability to the hospital for treatment. Give palliative and supportive care in place.

HOSPITAL SETTINGS

Hospital Administrative Roles – General		
Triage Level 1	**Triage Level 2**	**Triage Level 3**
1) **Preserve bed capacity by:** • Canceling all category 2 and 3 • elective surgeries, and advising all category 1 elective surgery patients of the risk of infection. • Canceling any elective surgery • that would require postoperative hospitalization. **Note:** Use standard operation and triage decision for admission to ICU since there are still adequate resources to accommodate the most critically ill patients. 2) **Preserve oxygen capacity by:** • Phasing out all hyperbaric medicine treatments. • Ensuring that all liquid oxygen tanks are full. 3) **Improve patient care capacity** by transitioning space in ICUs to accommodate more patients with respiratory failure. 4) **Control infection** by limiting visitation (follow hospital infection control plan).	1) **Preserve bed capacity** by: Canceling all elective surgeries unless • necessary to facilitate hospital discharge. Evaluating hospitalized category 1 elective surgery patients for discharge using same criteria as medical patients. 2) **Preserve oxygen capacity** by stopping all hyperbaric treatments. 3) **Improve patient care capacity** by implementing altered standards of care regarding nurse/patient ratios and expanding capacity by adding patients to already occupied hospital rooms. 4) **Provide emotional support** by initiating pre-established action team to provide counseling and care coordination and to work with the families of loved ones who have been denied life-sustaining treatment.	1) **Preserve bed capacity** by limiting surgeries to patients whose clinical conditions are a serious threat to life or limb, or to patients for whom surgery may be needed to facilitate discharge from the hospital.

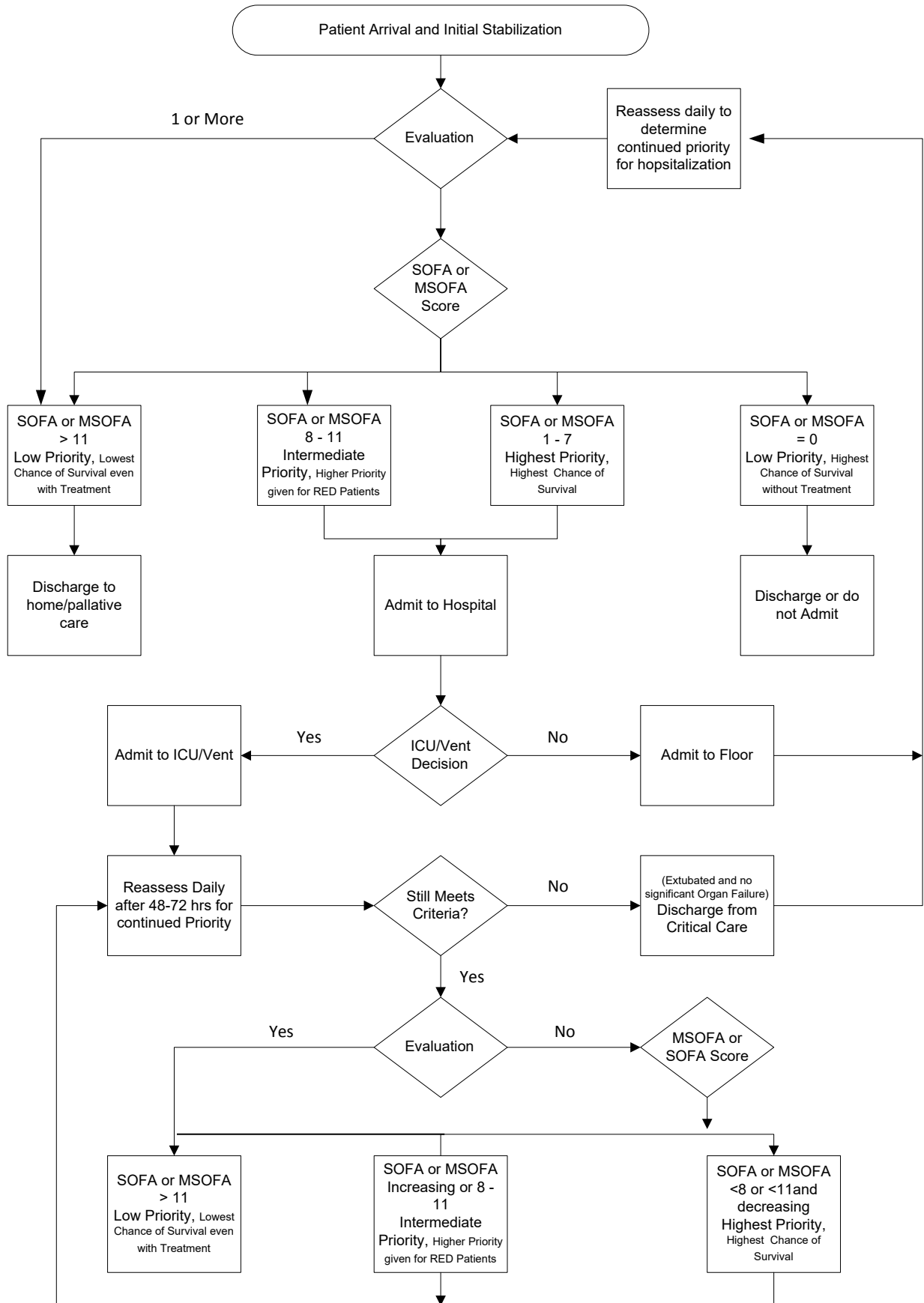## Emergency Department, Hospital, and ICU - Clinical Triage

Use **HOSPITAL AND ICU/VENTILATOR ADMISSION TRIAGE** algorithm and tools (pages 4 and 5) to determine which patients to send home for palliative care or medical management and which patients to admit or keep in hospital or ICU. Note that the lowest priority for admission is given to patients with the lowest chance of survival with or without treatment, and to patients with the highest chance of survival without treatment. The Sequential Organ Failure Assessment (SOFA) Score or the Modified-SOFA (MSOFA) can be used. Utilization of SOFA requires additional blood tests. Modified SOFA only requires creatinine measurement. The cutoffs remain the same using either score, and the prediction for both is essentially the same. A reasonable modification of SOFA may be a necessary accommodation for patients with a disability (e.g., deafness, cognitive or mobility limitations).

Physician judgment should be used in applying these guidelines. Decisions should be based on an individualized assessment of the patient based on the best available objective medical evidence.

Triage Level 2**:** Initiate **HOSPITAL AND ICU/VENTILATOR ADMISSION TRIAGE** algorithm (page 4) to determine priority for ICU admission, intubation, and/or mechanical ventilation. Reassess need for ICU/ventilator treatment daily after 48-72 hours of ICU care.

Triage Level 3**:** Continue to use **HOSPITAL AND ICU/VENTILATOR ADMISSION TRIAGE** algorithm (page 4) to determine priority for ICU, intubation, and/or mechanical ventilation. Triage more yellow patients to floor on oxygen or CPAP. Triage more red patients who are intubated and on CPAP to floor.

ALGORITHM: Hospital and ICU/Ventilator Admission Triage

Patient Arrival and Initial Stabilization

Evaluation

Reassess daily to determine continued priority for hopsitalization

1 or More

SOFA or MSOFA Score

SOFA or MSOFA > 11
Low Priority, Lowest Chance of Survival even with Treatment

SOFA or MSOFA 8 - 11
Intermediate Priority, Higher Priority given for RED Patients

SOFA or MSOFA 1 - 7
Highest Priority, Highest Chance of Survival

SOFA or MSOFA = 0
Low Priority, Highest Chance of Survival without Treatment

Discharge to home/pallative care

Admit to Hospital

Discharge or do not Admit

Admit to ICU/Vent ← Yes — ICU/Vent Decision — No → Admit to Floor

Reassess Daily after 48-72 hrs for continued Priority → Still Meets Criteria? — No → (Extubated and no significant Organ Failure) Discharge from Critical Care

Yes

Evaluation — No → MSOFA or SOFA Score

Yes

SOFA or MSOFA > 11
Low Priority, Lowest Chance of Survival even with Treatment

SOFA or MSOFA Increasing or 8 - 11
Intermediate Priority, Higher Priority given for RED Patients

SOFA or MSOFA <8 or <11and decreasing
Highest Priority, Highest Chance of Survival

SOFA or MSOFA may be utilized in connection with an individualized assessment of the patient based on the best available objective medical evidence. A reasonable modification of SOFA may be a necessary accommodation for patients with a disability.

This algorithm should not be construed to authorize the re-allocation of personal ventilators (defined as a ventilator brought by the patient to the acute care facility at admission to continue the patient's pre-existing personal use with respect to a disability).

Triage Tools

Modified Sequential Organ Failure Assessment (MSOFA)

Variable	MSOFA				Score each row
	1	**2**	**3**	**4**	
Respiratory PaO2/FiO2 (mmHg)	< 400	< 300	< 200 and mechanically ventilated	<100 and mechanically ventilated	
Nervous Glascow Coma Scale	13-14	10-12	6-9	<6	
Cardio Vascular	MAP <70mm/Hg	dop<=5 or dob (any dose)	dop>5 or epi<=0.1 or nor<=0.1	dop>15 or epi>0.1 or nor>0.1	
Liver Bilirubin (mg/dl)	1.2 - 1.9	2.0-5.9	6.0-11.9	>12.0	
Coagulation Plateletsx10-3/µl	<150	<100	<50	<20	
Renal Creatinine (mg/dl)	1.2-1.9	2.0-3.4	3.5-4.9	>5.0	
	Total MSOFA score = add score from all				

dop= dopamine in micrograms/kg/min
epi = epinephrine in micrograms/kg/min
nor = norepinephrine in micrograms/kg/min

SOFA or MSOFA may be utilized in connection with an individualized assessment of the patient based on the best available objective medical evidence. A reasonable modification of SOFA may be a necessary accommodation for patients with a disability. Assessment tools, such as the SOFA, may need reasonable modifications with respect to disabilities not related to their likelihood of surviving treatment. For example, the Glasgow Coma Scale, a tool for measuring acute brain injury severity in the SOFA, adds points to the SOFA score when a patient cannot articulate intelligible words or has difficulty with purposeful movement. For patients with pre-existing speech disabilities or disabilities that effect motor movement, this may result in a higher SOFA score even in instances where the patient's disability is not relevant to short-term mortality risk.